Print Name:____**DOB:**___________________

Pharmacy:_______________________________________**Phone:**______________________

PATIENT MEDICAL HISTORY **Height**__________**Weight**__________

YES	NO	
____	____	Diabetes
____	____	Hypertension
____	____	High Cholesterol
____	____	GERD
____	____	Gastric Ulcer
____	____	Asthma
____	____	Chronic Bronchitis
____	____	COPD/Lung Disease
____	____	Cardiac Disease; if yes type_________________________________
____	____	Blood Disorder; if yes type__________________________________
____	____	Kidney Disease
____	____	Psychiatric Disorder
____	____	Stroke
____	____	Seizures
____	____	Cancer: if yes type_____________________________________
____	____	Thyroid disease; if yes type__________________________________
____	____	Bowel Disease; if yes type___________________________________
____	____	Vitamin Deficiency; if yes type_______________________________
____	____	Environmental Allergies
____	____	Other____

Personal History Skin Cancer: (Please circle all that apply) BCC SCC Melanoma
____
____

Reason for Visit: ____
____
____

Any Changes in Moles, Trouble Healing, Or Thickening of Scars:___________________
____

List Surgeries:____
____
____

List Hospitalizations:____
____
____

ALLERGIES

____**No Known Allergies**

____Adhesive/Tape

____Local Anesthetics

____Anesthetics ____Aspirin

____Penicillin ____Demerol

____Codeine ____Eggs

____Sulfa ____IV Dye

____Latex

Other:___________________________

CURRENT MEDICATIONS

1.____________________________

2.____________________________

3.____________________________

4.____________________________

5.____________________________

6.____________________________

7.____________________________

8.____________________________

9.____________________________

10.___________________________

11.___________________________

12.___________________________

SOCIAL HISTORY USE OF:

Alcohol:_____Never_____Rarely_____Moderately_____ Daily

Recreational Drugs:_____Never_____Rarely_____Moderately_____Daily

Tobacco:_____Never_____Former Use_____Current Use_______#PPD X ______ yrs

FAMILY HISTORY **FAMILY MEMBER**

____Skin Cancer: BCC SCC Melanoma _______________

____High Cholesterol: __________________________________

____Thyroid Disease: ___________________________________

____Diabetes: ____

____Heart Disease:______________________________________

FAMILY HISTORY **FAMILY MEMBER**

____Cancer: ____

____COPD/Lung Disease: _________________________________

____Kidney Disease: ____________________________________

____High Blood Pressure: _________________________________

____Other: ____

CONSENT: I certify that the above information is true and correct to the best of my knowledge. I give permission to Tina Snodgrass, APRN to administer and perform care as needed based on the above information I listed.

Patient/Guardian Signature: ____ **Date:** ________________________